Training Center Staffing

Interim Update report

Office of Inspector General

Training Center Staffing Update

Introduction: The purpose of this report is to provide an update regarding access to staff in Training Centers operated by the Commonwealth of Virginia in 2003.

Background: Currently the Commonwealth of Virginia operates five training centers. Training centers are designed to provide housing and day services for persons with mental retardation. In 1990, the Federal Department of Justice (DOJ) began an investigation that resulted in eventual allegations that Northern Virginia Training Center (NVTC) was violating the civil rights of residents under the Civil Rights for Institutionalized Persons Act (CRIPA). In order to remedy this situation, additional resources were provided in to create a more safe environment in which residents had more access to more specialized professionals and monitoring through direct care staff. This was accomplished through a combination of additional funding as well as a reduction in the census of this facility.

During the year 2000-2001, a number of issues came to the attention of the Office of the Inspector General (OIG) reflecting general safety concerns at the training centers that had not been the subject of DOJ investigation. There were concerns that the same or worse conditions that led to DOJ investigation at NVTC existed at the remaining four centers. The OIG conducted a review of the clinical risk associated with conditions at these facilities. This was brought to the attention of then Governor Gilmore in 2001as is required in the powers and duties of the IG in VA Code: 37.1-256. It was the determination of the OIG that residents within four of the Training Centers were at risk due to inadequate access to certain professional staff as well as insufficient numbers of direct care staff. It was determined that there may be legitimate risk that persons within these other facilities were not receiving care consistent with the rights of institutionalized persons as is established under CRIPA.

Persons with severe mental retardation often have complex medical problems. Difficulty with mobility and walking are common. Many residents in Training Centers are wheelchair bound due to various physical muscular disabilities. Serious impairments in eating and swallowing are common and can be associated with risk of death due to aspiration. Two significant components of basic care include the development of a professionally prepared nutritional management plan and comprehensive physical management plan for residents. There are plans developed and periodically revised by trained professionals such as speech therapists, occupational therapists, nutritionists, and physical therapists. They are generally implemented by supervised and trained direct care staff.

The amount of overtime required to maintain minimal levels of direct care staffing at several of the facilities posed an unacceptable risk for abuse and neglect. Fatigued and overextended direct care staff can not properly implement nutritional and physical management plans, perform other aspects of daily treatment, promote good resident hygiene and can not safely monitor individuals with this level of disability. Although independence is a goal, in many cases the individuals residing within these institutions at this time are virtually completely dependent on others to perform many basic daily functions.

Summary of Recommendations in 2001: A comparative review of staffing patterns within the five training centers was conducted in 2001. This review was completed after experience with numerous inspections at each of these facilities.

Residents were determined to be of similar level of disability at each of the five training centers. The variation in staffing patterns was not justified by clinical need. In other words, residents at the more highly staffed institution are not more impaired than residents at other facilities in Virginia by reviewing basic demographics about these individuals. Similar proportions of the residents are wheelchair bound and require assistance with routine functioning. There was a similar distribution in the severity and degree of mental retardation. There was a slight increase in the proportion of older individuals at CVTC than the other four centers, but this was not deemed to be significantly different in terms of staffing needs. (see Figure 1. below.)

During August 2001 a presentation was made to the Office of the Governor and the Secretary of Health and Human Resources regarding the findings of this review. Several general recommendations were made which included:

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Provide more direct care staff, particularly at SWVTC and SEVTC.

The most immediate need at several facilities was additional direct care staff in order to decrease the frequency of mandatory overtime. Additional direct care staff would decrease the risk for abuse and neglect, provide increased time for training and supervision, and provide increased opportunities to implement a variety of programs such as proper feeding (prevent choking, and aspiration), behavior management (lessen injuries, and aggression), physical

management (prevent deterioration of mobility) and physical therapy (improve functioning).

Provide more Professional staff, particularly at SWVTC and SEVTC

This would allow more residents to have access to contemporary professional treatment plans in order to reduce the risk of medical complications and even premature death. This would include professional assessment and development of nutritional management plans, which would lessen risks of aspiration and other consequences of malnutrition. The development of physical management plans would provide for appropriate wheelchair fitting, ambulation, and appropriate training on the safe transfer of individuals to avoid fractures and other injuries. Behavioral management plans with increased sophistication would enable more safe and humane treatment of individuals with aggressive outbursts. In addition to more access to evaluation and development of plans, more professional staff would enable opportunities to observe and supervise the actual implementation of these plans of treatment by direct care staff. Professional and supervisory staff can also be helpful in facilitating modeling of positive behavior and interactions with challenging residents.

Prioritize the Census reduction plan at CVTC and SVTC to improve staff to resident ratios.

This was suggested at a time when there were considerable numbers of persons on waiting lists to receive community care at these two large facilities. As can be seen in Figure 2, there have been reductions in the census at these two large facilities over the last 10 years. Prioritization of census reduction within CVTC and SVTC would result in safer conditions within these facilities and would allow for a positive adjustment in resident to staff ratios, so that the remaining residents would have greater access to direct care and professional staff.

Response: In association with this information as well as other concerns about the level of care within these facilities, significant additional resources were made immediately available to four centers: CVTC, SVTC, SEVTC and SWVTC. These resources have been carried forward in subsequent budgets.

The purpose of this report is to report on the utilization of these resources to meet the direct needs of residents at these facilities. This is a preliminary review. This information will be used and incorporated into onsite inspections at all training centers throughout the next year.

Figure 1. Current Facility Census

(As Of July 1, 2002)

Census/ age	NVTC	SEVTC	SWVTC	SVTC	CVTC
<18	0	0	1	1	4
18-21	2	11	9	3	2
22-30	27	50	29	17	18
31-40	74	65	50	105	100
41-50	49	46	70	167	**322**
51-60	31	14	35	65	91
61-70	6	5	19	29	52
> 71	3	1	4	21	26
TOTALS	**192**	**192**	**217**	**408**	**615**

Figure One demonstrates the distribution of age of he residents at these facilities. At CVTC over half of current residents are in the 41 to 50 age range, and very few are less than 30. The average lifespan of individuals with serious and profound mental retardation is often shortened. A study completed by Strauss in 1991, estimated an average life expectancy of Down's syndrome to be 55 years and for profound mental retardation to be 43 years. A study conducted by the OIG of mortalities in Virginia Training Centers in 2000 found an average age of death in these residents to be 53.6 years. As the Individuals with Disabilities Education Act has enabled more children to have greater access to traditional public education, very few young children now receive services in Virginia's Training Centers. It is unusual to have persons less than 21 years old in facilities. Generally younger persons are admitted when they have serious behavioral problem or serious physical need that cannot be accommodated in a community or home setting. It is common for individuals to experience disturbances as they transition into a community setting after completing school at age 21. In short, primarily due to the IDEA, the rate of admissions into the Training Centers has declined considerably over the last twenty years.

Figure 2. Historic Comparative Census Since 1990

Census	NVTC	SEVTC	SWVTC	SVTC	CVTC
1990	**261**	**192**	**217**	**664**	**1326**
1995	**211**	**190**	**214**	**583**	**929**
6-2001	**189**	**198**	**220**	**426**	**645**
7-2002	**192**	**192**	**217**	**408 (2x)***	**615 (3x)***

* 2x and 3x serve as reminders that SVTC census is approximately 2 times that of the roughly 200 bed, smaller training centers; and current CVTC census is approximately 3 times the census.

Figure two demonstrates a decline over the last ten years in census. Reduction is seen primarily in the two largest facilities, CVTC and SVTC. In response to DOJ concerns, NVTC did experience a reduction from a capacity of 270 to an average census of about 200 between 1990 and 1995.

Figure 3. Current Operating Budget In Millions

(As of August 23, 2002)

	NVTC	SEVTC	SWVTC	SVTC*	CVTC
FY 2002	**27.6**	**17.1**	**16.6**	**59.5**	**68.7**
FY 2003	**27.8**	**18.5**	**17.7**	**61.6**	**70.5**

*The budget at SVTC includes additional funds for Grounds and Maintenance support for the entire Petersburg campus. This includes two other state facilities.

Figure 3 represents the current operating budgets as reported by each facility to OIG upon request and is presented for comparative information.

Figure 4. Total Number Of Staff Positions

(As of August 23, 2002)

	CVTC	SVTC	NVTC	SEVTC	SWVTC

Total Staff 1995	**1835**	**1527****	**484**	**357**	**381**
Total Mel 2002	**1584**	**1507**	**517.5**	**414**	**468**
Positions Filled 2002	**1500.5**	**1369**	**504.5**	**415***	**437.5**

*SEVTC included P-14 positions into the total for 2002, approximately 25 positions.

**SVTC shows more Mel (Maximal Employment Level) and staff because SVTC also provides grounds support for two other state facilities on the Petersburg campus.

Figure 5. Comparison Of Professional Staff

For The Three Smaller Training Centers

(August 23, 2002)

	NVTC		**SEVTC**		**SWVTC**	
STAFF POSITIONS	FY O2	**FY 03**	FY 02	**FY03**	FY02	**FY03**
Psychology	12*	11.75	4	***4.4****	3	***6****
Speech Therapy	5	4.5	4	***5***	3	3
Occupational Therapy	11	10.5	3	***4.5***	2	2
Physical Therapy	10	8.75	2	2	4	3.5
Recreational Therapy	7	6.75	7	***7.5***	4	4

MD psychiatrist	0.5	0.75	0.2	***0.5***	0.05	***0.1***
MD primary care	3	3	1	***2***	1	1
Nurse Practitioner	0	0	1	1	0	***1***

* NVTC has 5PhD psychologists, 1 MA psychologists and 5.75 psychology assistants

* SEVTC has .4 position of a PhD psychologist, 4 MA level and 0 assistants

* SWVTC has 0 PhD psychologists, 3 MA level and 3 assistants

*Numbers in boldface type represent increases over the last year.

Figure 5 provides information regarding the changes in professional staffing for the three smaller and similarly sized facilities over this one-year period. There were modest but significant increases in availability of professional staffing in these two centers. In general these facilities used resources to increase areas of most deficiency, for SWVTC, this was primarily in Direct Care staff, for SEVTC it was a mixture of direct care and professional staff. There continue to be concerning differences in Occupational Therapy and Speech Therapy at SWVTC. These are the professionals most likely to be involved in Nutritional Management programming, which is essential in maintenance of adequate health and reduction of risk of aspiration and choking for many of these individuals.

Figure 6. Comparison of Current Professional Staffing of all Five Training Centers.

	NVTC	SEVTC	SWVTC	SVTC (2x)*	CVTC (3x)**	*
Psychology	11.75	4.4	6	**15**	**19**	
Speech Therapy	4.5	5	3	**6**	**6**	
Occupational Therapy	10.5	4.5	2	**18**	**23**	
Physical Therapy	8.75	2	3.5	**13**	**18**	
Recreational Therapy	6.75	7.5	4	**8**	**8 (all only aids)**	
MD Psychiatrist	0.75	0.5	0.1	**1**	**1**	
Primary Care	3	2	1	**5**	**8**	
Nurse Practitioner	0	1	1	**0**	**1**	

SVTC census is about 2 times that of NVTC, SEVTC and SWVTC,

**CVTC census is about 3 times that of NVTC, SEVTC and SWVTC.

Figure 6 includes a comparison of all staffing at all five training centers at this time. This information from one year ago at the two larger facilities is not available for comparison. For this chart comparison, staff of all levels of training have been collapsed into the general category of their occupation. For Example, in looking at Psychology, NVTC has 5 PhD level psychologists, SEVTC has .4, SWVTC has none, SVTC has 2 and CVTC has 3. The remainder of psychology staff are either MA level Psychologists or specialized direct care staff called Psychology Aids. Similarly, Occupational Therapy in the above chart includes Occupational Therapists as well as Certified Occupational Therapy Aids and OT Aids (Non-certified). Physical Therapy includes Physical Therapists as well as Licensed Physical Therapy Aids and specialized direct care staff called Physical Therapy Aids. This chart demonstrates clear differences in access to these types of professional staff at these five training centers in Virginia.

With additional resources, each of the four training centers was able to increase professional staff in areas.

SWVTC prioritized the hire of a family nurse practitioner. This individual has already initiated a number of health maintenance programs for the residents, provides relief coverage for the medical director and has become the Director of Nursing.

SEVTC added a full-time physician, an occupational therapist, a recreational therapist, a recreational therapy assistant, a rehab technician and a licensed physical therapy aide. In addition, SEVTC increased psychologists and psychiatric time by eight hours per week each.

CVTC added a contract psychiatrist and SVTC was able to increase psychiatrist time, hire a QMRP Case Manager Director and a Nutritional Management Trainer.

Figure 7. Comparison Of Nursing Staff

(As Of August 23, 2002)

STAFF POSITIONS	NVTC	SEVTC	SWVTC	SVTC (2x)	CVTC (3x)
RN	23	19	21	28	64
LPN	4.75	6	6	65	29
C.N.A.	0	0	0	0	153

Figure 7 depicts the numbers of nursing staff currently available at each of the five training centers. With the exception of SVTC, there are similar ratios of RN care available. This is compensated for somewhat at SVTC by increased access to LPNs which are the staff who actually administer medication at this facility. In order to administer medication within these facilities, an individual has to receive medication administration training, but does not need to be a nurse by training. CVTC has greater CNA positions due in part to the presence of a unit which provides skilled nursing home level of care. CVTC has relatively lower numbers of Direct Care staff (see Figure 8) per resident, which may be compensated for in part with the higher number of CNA's at this facility.

Figure 8. Comparison Of Direct Care Staff

(August 2002)

Direct Care Staff (Direct Service Associate, DSA)	**NVTC**	**SEVTC**	**SWVTC**	**SVTC** **(2x)**	**CVTC (3x)**
2001	**275**	**232**	**206**		
8/2002	**265**	**243**	**253**	**605**	**651**

Figure 8 presents information on the numbers of direct care staff at all five training centers. All four facilities that received additional resources, enhanced direct care staffing. The most substantial increases in direct care staffing occurred at SWVTC and SEVTC. This is where the greatest need had been identified.

SWVTC secured 29 DSA positions and 2 RNs. This has also allowed for increased opportunities for programming for the residents and a decrease in the use of the extensive overtime, which was required to maintain safe levels of staffing. This has resulted in an increase in staff morale as noted through OIG interviews with direct care and administrative staff. SEVTC obtained 12 new DSAs, and 2 Direct Services Supervisors.

This brings the level of staffing up to a much more safe level which is also more in line with recommended staffing levels as negotiated in the DOJ settlement agreement with NVTC.

Summary

This brief report demonstrates a clear progress in increasing direct care and professional staff at four Training Centers in Virginia over the last year. This progress greatly mitigates the risk that was present for individuals at four of our training centers in Virginia. This brings these four centers into much less risk of violation of an institutionalized individual's right to active treatment in a safe environment under CRIPA.

This is an informational report and will utilized as a reference throughout the year and over time to follow

developments in staffing at these critical institutions. There are not specific recommendations associated with this report per se; ongoing resident access to appropriate levels of care within each facility will continue to be developed with recommendations made at each facility as they are inspected throughout the year.

References:

Strauss, D and Eyman, RK. *Mortality of people with Mental Retardation in California with and without Down syndrome, 1986-1991*. Am J Ment Retard, 1996 May; 100(6):643-53).